



2829 University Avenue SE #200
 Minneapolis, MN 55414-3253
 (612) 317-3000 – Voice (612) 617-2190 – Fax
 Toll Free (888) 234-2690 (MN, IA, ND, SD, WI)
 (800) 627-3529 – TTY
 Email: nursing.board@state.mn.us
 Website: www.nursingboard.state.mn.us

ADVANCED PRACTICE REGISTERED NURSE LICENSURE APPLICATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

Until you are issued a license, all data submitted on the application, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application, except social security number and responses to grounds for denial questions, become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

•Type or print clearly •Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION											
LAST NAME				FIRST NAME				MIDDLE NAME			
								<input type="checkbox"/> No middle name			
MAIDEN NAME				OTHER LAST NAME(S)				PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business ()			
STREET ADDRESS											
CITY				STATE/PROVINCE				ZIP/POSTAL CODE		COUNTRY	
EMAIL ADDRESS											
MINNESOTA LICENSE NUMBER <input type="checkbox"/> RN				BIRTH DATE (mm/dd/yyyy)				GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female			
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72				<input type="checkbox"/> I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number				MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72			
<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>								<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>			
APRN PROGRAM NAME								COMPLETION DATE (mm/dd/yyyy)			
BUSINESS ADDRESS: Minn. Stat. Sec. 214.073 requires licensees to provide their primary business address at the time of initial application and all renewals. Your license will not be issued unless you provide it or check the box below certifying that you are not currently in the workforce related to your practice.											
FACILITY NAME											
STREET ADDRESS											
CITY						STATE/PROVINCE			ZIP/POSTAL CODE		
<input type="checkbox"/> I certify that I am not currently in the workforce related to my practice and I don't have a business address related to my practice.											
APRN ROLE (A separate application is required for each role)											
<input type="checkbox"/> NURSE PRACTITIONER						<input type="checkbox"/> NURSE MIDWIFE					
<input type="checkbox"/> NURSE ANESTHETIST						<input type="checkbox"/> CLINICAL NURSE SPECIALIST					
POPULATION FOCUS (Check all statements that apply)											
<input type="checkbox"/> ADULT GERONTOLOGY				<input type="checkbox"/> PEDIATRIC				<input type="checkbox"/> PSYCHIATRIC/MENTAL HEALTH			
<input type="checkbox"/> NEONATAL				<input type="checkbox"/> ACUTE CARE (if appropriate)				<input type="checkbox"/> PRIMARY CARE (if appropriate)			
<input type="checkbox"/> WOMEN'S HEALTH				<input type="checkbox"/> FAMILY							

CURRENT CERTIFICATION			
Applicant must request documentation of current certification in good standing be sent directly from the certifying body to the Board.			
CERTIFYING ORGANIZATION	CERTIFICATION TYPE	EFFECTIVE DATE	EXPIRATION DATE
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PRESCRIBING			
PRESCRIBING PHARMACOLOGICAL INTERVENTIONS		<input type="checkbox"/> YES <input type="checkbox"/> NO	
PRESCRIBING NON-PHARMACOLOGICAL INTERVENTIONS		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DEA NUMBER	STATE ISSUED		
DEA NUMBER	STATE ISSUED		
GROUND FOR REVIEW OF APPLICATION			
Provide a written explanation for every Yes response.			
<ol style="list-style-type: none"> 1. Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or country? <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 2. Have you ever violated a state or federal law or rule relating to narcotics or controlled substances or other similar regulations? <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 3. Have you ever been convicted, entered a plea of guilty, <i>nolo contendere</i>, or no contest, for any felony, gross misdemeanor or misdemeanor offense? <i>NOTE: The fact that a conviction has been pardoned, expunged, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."</i> <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 4. In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent? <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 5. Have you been fired from a nursing-related job in the last five years due to conduct that may be grounds for disciplinary action under the Nurse Practice Act? <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 6. Are you under investigation or are you the subject of any pending or past disciplinary action or have you ever been refused a nursing license or any other occupational license in any state, territory or country? <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 7. Do you have any physical or mental disability or illness that may impair your ability to practice nursing with reasonable skill and safety? <i>NOTE: If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question.</i> <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a statement explaining management and treatment is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a statement explaining management and treatment is attached. <input type="checkbox"/> No. 8. Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid? <input type="checkbox"/> Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached. <input type="checkbox"/> No. 			
I affirm that the statements and documents provided by me during the application process are true and correct.			
_____ Legal Signature		_____ Date (mm/dd/yyyy)	



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CONFIRMATION OF PROGRAM COMPLETION - ADVANCED PRACTICE REGISTERED NURSE

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements.

Until you are licensed, all data submitted on this form, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the form become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

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APPLICANT INFORMATION

Complete the applicant information. If you do not have a graduate education as an APRN in one of the four roles and one of the six population foci, check the appropriate box and verify that you were recognized by the Minnesota Board of Nursing to practice as an APRN on July 1, 2014. This means that the Board had a current copy of your certification as an APRN. If you do not have a graduate level education and you were not recognized by the Board of Nursing to practice as an APRN on July 1, 2014, you are not eligible for licensure as an APRN in Minnesota. Sign and date the document. The *Affidavit Section* is to be completed by the school official of the APRN program you attended. Mail the document to the appropriate APRN program.

LAST NAME		FIRST NAME		MIDDLE NAME	
				<input type="checkbox"/> No middle name	
MAIDEN NAME		OTHER LAST NAME(S)		PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Business ()	
MINNESOTA LICENSE NUMBER <input type="checkbox"/> RN _____				BIRTH DATE (mm/dd/yyyy)	
APRN PROGRAM NAME (no initials)					
CITY AND STATE OF APRN PROGRAM				COMPLETION DATE (mm/dd/yyyy)	
<input type="checkbox"/> I authorize _____ (name of APRN program) to release my educational dates to the Minnesota Board of Nursing.					
<input type="checkbox"/> I do not meet the requirements for completion of graduate level education as an APRN in one of the four APRN roles and population focus. <input type="checkbox"/> I was recognized by the Board to practice as an APRN prior to and on July 1, 2014.					
_____ Legal Signature				_____ Date (mm/dd/yyyy)	

-over-

Applicant: Complete the *Applicant Information* section above and forward to your school of nursing for completion. If the school official is not able to verify completion of all requirements, contact the Board of Nursing for further instructions.

School Official: Complete *Affidavit* section below.

AFFIDAVIT SECTION

↓ **This Section for School Use Only - Applicant: Do Not Write Below This Line** ↓

SCHOOL OFFICIAL: Complete Affidavit Section after the above named applicant has fulfilled all the requirements of the nursing program and is eligible for graduation.

PROGRAM INFORMATION

Was the APRN program at a graduate level? YES ☐ NO ☐

ROLE PREPARATION:

☐ Nurse Practitioner ☐ Registered Nurse Anesthetist ☐ Clinical Nurse Specialist ☐ Nurse Midwife

POPULATION FOCUS:

☐ Adult-Gerontology ☐ Family and Individual ☐ Neonatal ☐ Pediatric ☐ Women's and Gender Health

☐ Psychiatric and Mental Health

☐ Acute (if applicable)

☐ Primary (if applicable)

Is the program accredited by a national nursing accrediting agency? YES ☐ NO ☐

Is approval of the nursing program required by the Board of Nursing? YES ☐ NO ☐

Name of the Board of Nursing granting program approval _____

NAME OF ACCREDITATION BODY

DATES OF CURRENT ACCREDITATION
(mm/dd/yyyy-mm/dd/yyyy)

DEGREE TYPE

☐ Doctorate of Nursing Practice

☐ Masters

☐ Other (explain) _____

COMPLETION DATE (mm/dd/yyyy)

The undersigned does hereby affirm that the information provided is true and correct.

Signature of School Official

Name and Title (print)

Affix School Seal or Stamp

Return completed form to Minnesota Board of Nursing

Advanced Practice Registered Nurse Workforce Questionnaire 2014



You must provide this information as a matter of state law (Minn. Stat. 1440.51-011.052 and Minn. Rules 4695.0100-4695.0300). Your responses support statewide health workforce planning efforts in Minnesota. The information collected is classified as public. Per Minnesota Statutes, section 144.1485, you may request your practice addresses be classified as private if this classification is required for your safety. If you need assistance filling out this form, please call (651) 201-3838 or Toll Free (800) 366-5424.

Registered Nurse (RN) license number: _____

First Name _____ Middle Initial _____ Last Name _____

Section A: Training and Professional Information

1. What type of nursing degree or credential prepared you to practice as an APRN, regardless of where the license was obtained? (Select only **ONE**)

- ☐ Diploma - Nursing
- ☐ Associate Degree - Nursing
- ☐ Bachelor's Degree - Nursing
- ☐ Post-baccalaureate certificate - Nursing
- ☐ Master's Degree - Nursing
- ☐ Doctorate

2. Did you obtain the degree or credential listed above in Minnesota?

- ☐ Yes
- ☐ No

3. What other degrees have you earned, if any? (Select **all that apply**)

- | | | |
|---|--|---|
| <input type="checkbox"/> Associate Degree, Nursing | <input type="checkbox"/> Master's Degree, Nursing | <input type="checkbox"/> Doctorate in Nursing (Other) |
| <input type="checkbox"/> Associate Degree, Non-Nursing | <input type="checkbox"/> Master's Degree, Non-Nursing | <input type="checkbox"/> Doctorate, Non-Nursing |
| <input type="checkbox"/> Bachelor's Degree, Nursing | <input type="checkbox"/> Doctorate in Nursing (PhD) | <input type="checkbox"/> Post-Master's Certificate |
| <input type="checkbox"/> Bachelor's Degree, Non-Nursing | <input type="checkbox"/> Doctorate in Nursing Practice (DNP) | <input type="checkbox"/> None |

4. If you are currently practicing as an APRN, how many more years do you plan to practice in Minnesota?

- ☐ 5 years or less
- ☐ 6-10 years
- ☐ More than 10 years
- ☐ Not practicing as an APRN in MN

If you answered #4 as "**5 years or less**," what is the main reason you plan to practice less than 6 years in MN?

- ☐ Retirement
- ☐ Work in another state
- ☐ Change professions
- ☐ Other (specify) _____

5. In the past 12 months, did you volunteer your time to provide nursing services?

- ☐ Yes; estimated hours in past 12 months _____
- ☐ No

6. Which of the following choices best describes your current employment status? (Select only **ONE**)

- ☐ Employed in a paid position as an APRN
- ☐ Employed in another field, but seeking work as an APRN
- ☐ Employed in another field and not seeking work as an APRN
- ☐ Unemployed, but seeking work as an APRN
- ☐ Unemployed and not seeking work as an APRN
- ☐ Not currently working due to family or medical reasons
- ☐ Retired
- ☐ Student (specify major, field or degree program) _____

Section B: Employment Information

7. How many weeks did you work as an APRN in the past year? _____ weeks

8. How many hours do you work as an APRN in a typical week? _____ (On average)

9. How many patients do you see in a typical week? _____ (if none, write 0).

Site One

Please provide the following information about the site **where you work the most hours weekly** in a job that requires an APRN license. If you are not working in a position that requires an APRN license, please skip to questions 19 & 20.

10. Name of work site (clinic, hospital, university, etc.) _____

Street Address _____ City _____ State _____ Zip code _____

Site One <i>continued</i>	11. Number of years you have worked at this location _____																									
	12. Number of hours you work in a TYPICAL WEEK at this location _____ (On average)																									
	13. How many hours per week do you provide care directly to patients at this location? _____ hours per week																									
	14. What type of practice setting best describes the site where you work the most APRN hours weekly? (Please select only ONE BOX) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Academic (teaching or research)</td> <td><input type="checkbox"/> Federally Qualified Health Center</td> <td><input type="checkbox"/> Policy/Planning/Regulatory</td> </tr> <tr> <td><input type="checkbox"/> Ambulatory care/Clinic</td> <td><input type="checkbox"/> Home health agency</td> <td><input type="checkbox"/> Private industry/organization</td> </tr> <tr> <td><input type="checkbox"/> Ambulatory surgical center</td> <td><input type="checkbox"/> Hospice</td> <td><input type="checkbox"/> Rehabilitation facility</td> </tr> <tr> <td><input type="checkbox"/> Community/Public health</td> <td><input type="checkbox"/> Hospital</td> <td><input type="checkbox"/> School (K-12)/College/University health clinic</td> </tr> <tr> <td><input type="checkbox"/> Convenience/Retail/Walk-in clinic</td> <td><input type="checkbox"/> Insurance company</td> <td><input type="checkbox"/> Solo practice</td> </tr> <tr> <td><input type="checkbox"/> Correctional facility</td> <td><input type="checkbox"/> Nursing Home/ Long-term care/</td> <td><input type="checkbox"/> Urgent care clinic</td> </tr> <tr> <td><input type="checkbox"/> Drug/Medical device industry</td> <td>Extended care/Assisted living facility</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>		<input type="checkbox"/> Academic (teaching or research)	<input type="checkbox"/> Federally Qualified Health Center	<input type="checkbox"/> Policy/Planning/Regulatory	<input type="checkbox"/> Ambulatory care/Clinic	<input type="checkbox"/> Home health agency	<input type="checkbox"/> Private industry/organization	<input type="checkbox"/> Ambulatory surgical center	<input type="checkbox"/> Hospice	<input type="checkbox"/> Rehabilitation facility	<input type="checkbox"/> Community/Public health	<input type="checkbox"/> Hospital	<input type="checkbox"/> School (K-12)/College/University health clinic	<input type="checkbox"/> Convenience/Retail/Walk-in clinic	<input type="checkbox"/> Insurance company	<input type="checkbox"/> Solo practice	<input type="checkbox"/> Correctional facility	<input type="checkbox"/> Nursing Home/ Long-term care/	<input type="checkbox"/> Urgent care clinic	<input type="checkbox"/> Drug/Medical device industry	Extended care/Assisted living facility	<input type="checkbox"/> Other _____			
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Site Two	Please complete the following information if you are working at an additional site requiring a current APRN license. This is the site where you work the second highest hours weekly. 15. Name of work site (clinic, hospital, university, etc.) _____ City _____ State _____ Zip code _____																									
16. Indicate all specialties in which you practice (regardless of work site/practice setting). (select ALL that apply) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Acute care/Critical care</td> <td><input type="checkbox"/> Intensive Care</td> <td><input type="checkbox"/> Pediatrics</td> </tr> <tr> <td><input type="checkbox"/> Adult Health/Family Health</td> <td><input type="checkbox"/> Maternal – Child Health</td> <td><input type="checkbox"/> Psychiatric/Mental/Behavioral Health/ Substance Abuse</td> </tr> <tr> <td><input type="checkbox"/> Anesthesia/Anesthesiology</td> <td><input type="checkbox"/> Medical/Surgical</td> <td><input type="checkbox"/> Public Health</td> </tr> <tr> <td><input type="checkbox"/> Community Health</td> <td><input type="checkbox"/> Neonatal/Perinatal</td> <td><input type="checkbox"/> School Health</td> </tr> <tr> <td><input type="checkbox"/> Emergency Care/Trauma</td> <td><input type="checkbox"/> Obstetrics/Gynecology (Women's Health)</td> <td><input type="checkbox"/> Other (Please specify) _____</td> </tr> <tr> <td><input type="checkbox"/> Geriatric/Gerontology</td> <td><input type="checkbox"/> Occupational Health</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Home Health</td> <td><input type="checkbox"/> Oncology</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Hospice/Palliative Care</td> <td><input type="checkbox"/> Operating Room/Recovery</td> <td></td> </tr> </table>			<input type="checkbox"/> Acute care/Critical care	<input type="checkbox"/> Intensive Care	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Adult Health/Family Health	<input type="checkbox"/> Maternal – Child Health	<input type="checkbox"/> Psychiatric/Mental/Behavioral Health/ Substance Abuse	<input type="checkbox"/> Anesthesia/Anesthesiology	<input type="checkbox"/> Medical/Surgical	<input type="checkbox"/> Public Health	<input type="checkbox"/> Community Health	<input type="checkbox"/> Neonatal/Perinatal	<input type="checkbox"/> School Health	<input type="checkbox"/> Emergency Care/Trauma	<input type="checkbox"/> Obstetrics/Gynecology (Women's Health)	<input type="checkbox"/> Other (Please specify) _____	<input type="checkbox"/> Geriatric/Gerontology	<input type="checkbox"/> Occupational Health		<input type="checkbox"/> Home Health	<input type="checkbox"/> Oncology		<input type="checkbox"/> Hospice/Palliative Care	<input type="checkbox"/> Operating Room/Recovery	
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17. Time spent in the following activities at your work site(s) (On average) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Activity</th> <th style="width: 30%;">Time in hours in a standard week</th> </tr> </thead> <tbody> <tr><td>Provide direct patient care</td><td>_____ hrs.</td></tr> <tr><td>Supervise patient care</td><td>_____ hrs.</td></tr> <tr><td>Administration of Practice</td><td>_____ hrs.</td></tr> <tr><td>Case Management</td><td>_____ hrs.</td></tr> <tr><td>Care Coordination with a Team</td><td>_____ hrs.</td></tr> <tr><td>Insurance/Utilization</td><td>_____ hrs.</td></tr> <tr><td>Telephone triage</td><td>_____ hrs.</td></tr> <tr><td>Teaching/Research</td><td>_____ hrs.</td></tr> <tr><td>School health</td><td>_____ hrs.</td></tr> <tr><td>Public Health</td><td>_____ hrs.</td></tr> <tr><td>Other _____</td><td>_____ hrs.</td></tr> </tbody> </table>			Activity	Time in hours in a standard week	Provide direct patient care	_____ hrs.	Supervise patient care	_____ hrs.	Administration of Practice	_____ hrs.	Case Management	_____ hrs.	Care Coordination with a Team	_____ hrs.	Insurance/Utilization	_____ hrs.	Telephone triage	_____ hrs.	Teaching/Research	_____ hrs.	School health	_____ hrs.	Public Health	_____ hrs.	Other _____	_____ hrs.
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Other _____	_____ hrs.																									
18. In addition to English, in which languages do you communicate for clinical purposes? (Select ALL that apply or "None") <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> None (English Only)</td> <td><input type="checkbox"/> Lao</td> <td><input type="checkbox"/> Somali</td> </tr> <tr> <td><input type="checkbox"/> Amharic</td> <td><input type="checkbox"/> Oromo</td> <td><input type="checkbox"/> Spanish</td> </tr> <tr> <td><input type="checkbox"/> Arabic</td> <td><input type="checkbox"/> Russian</td> <td><input type="checkbox"/> Swahili</td> </tr> <tr> <td><input type="checkbox"/> Hmong</td> <td><input type="checkbox"/> Serbo-Croatian</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td><input type="checkbox"/> Khmer</td> <td><input type="checkbox"/> Sign Language</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> </table>			<input type="checkbox"/> None (English Only)	<input type="checkbox"/> Lao	<input type="checkbox"/> Somali	<input type="checkbox"/> Amharic	<input type="checkbox"/> Oromo	<input type="checkbox"/> Spanish	<input type="checkbox"/> Arabic	<input type="checkbox"/> Russian	<input type="checkbox"/> Swahili	<input type="checkbox"/> Hmong	<input type="checkbox"/> Serbo-Croatian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Khmer	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Other (specify) _____									
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Section C: Race and Ethnicity Information																										
19. Are you of Hispanic, Latino or Spanish origin? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
20. What is your race? (Check ALL that apply) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> White</td> <td><input type="checkbox"/> Black/African American or African</td> <td><input type="checkbox"/> Native Hawaiian or other Pacific Islander</td> </tr> <tr> <td><input type="checkbox"/> Asian</td> <td><input type="checkbox"/> American Indian or Alaska Native</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> </table>			<input type="checkbox"/> White	<input type="checkbox"/> Black/African American or African	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Other (specify) _____																		
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